North Carolina Department of Health and Human Services
Beverly Eaves Perdue, Governor Lanier M. Cansler, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011• Fax 919-508-0951
Steven Jordan, Director

Division of Medical Assistance
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-855-4100 • Fax 919-733-6608
Craigan L. Gray, MD, MBA, JD, Director

February 24, 2011

MEMORANDUM

TO:
Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray

Steven Jordan SJ

SUBJECT: Implementation Update #85 - Revised

Implementation of the NCCI
CABHA Electronic Commerce Requirements
Auth/Billing prior to CABHA Enrollment
CST, IIH, DT after January 1, 2011
Endorsement Triple Time Frames
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Implementation of the National Correct Coding Initiative

The National Correct Coding Initiative (NCCI) was developed by the Centers for Medicare and Medicaid (CMS) to prevent improper payments when a provider would submit incorrect code combinations or to avoid payments of units of service that are medically unlikely to be correct. The requirement from CMS through the Affordable Care Act (ACA) is for all state Medicaid programs to be compliant with NCCI in claims processing by March 31, 2011. NCCI edits supersede the Medicaid State Plan, all N.C. Medicaid policies, bulletin articles, and other previous guidance provided on procedure-to-procedure and units-of-service edits.

For behavioral health services, NCCI edits apply to Independent Practitioners, Medical Practices, Outpatient Hospital services and Critical Access Behavioral Health Agencies in the provision of Current Procedural Terminology (CPT) codes. The basic elements are designed to eliminate duplicate billing as defined by:

- Recipient Medicaid Identification (MID), same date of service, same procedure code, same Attending Provider number and
- Inter-range procedure-to-procedure edits that define pairs of CPT codes that should not be reported together.

Behavioral health utilization review (UR) vendors may continue to approve these service combinations during the same authorization periods. It is the service provider who must manage the schedule and delivery of authorized services to ensure that differing treatments are not provided on the same date of service.

In review of current claims that fit these profiles, the most frequent errors were found to be between Individual Therapy and Family Therapy on the same date of service by the same Attending Provider. Specific prohibitions per procedure code are under development that will further guide practitioner service delivery and billing.

Upon implementation, an explanation and justification for all correct coding edits will be available on a claim-level basis through N.C. Electronic Claims Submission (NCECS) Web Tool. Preliminary guidance has been published in the October 2010, December 2010, and January 2011 Medicaid Bulletins. The Division of Medical Assistance (DMA) will continue to publish updates through the Medicaid Bulletin when the NCCI system and other correct coding edits are slated for implementation. Additional information is also available on DMA's NCCI web page (http://www.ncdhhs.gov/dma/provider/ncci.htm) and the CMS website at http://www.cms.gov/MedicaidNCCICoding/.

Critical Access Behavioral Health Agencies: Electronic Commerce Requirements for Billing

This article serves as a reminder to Critical Access Behavioral Health Agencies (CABHAs) that once you have completed the Medicaid provider enrollment process and received your CABHA Medicaid Provider Number (MPN) you must complete and submit an **Electronic Funds Transfer (EFT) Authorization Agreement for Automatic Deposits** to initiate the process for electronic payment of claims billed with the National Provider Identifier (NPI) associated with your CABHA MPN.

A separate **EFT Authorization Agreement** must be submitted for each MPN issued to a provider. A copy of the EFT Authorization Agreement can be obtained on DMA website at http://www.ncdhhs.gov/dma/provider/forms.htm. A voided check must be attached to the EFT Authorization Agreement to confirm the CABHA's account number and bank transit number. Completed forms can be returned by fax to the HP Enterprise Services Financial Unit at 919-816-3186 or by e-mail to NCXIXEFT@hp.com.

Remittance and Status Reports (RAs) are available only through the N.C. Electronic Claims Submission/Recipient Eligibility Verification Web Tool (NCECSWeb Tool). Therefore, CABHAs must also complete and submit a **Remittance and Status Reports in PDF Format and NCCI Information Request Form** to obtain a logon ID and password to their RAs for claims billed with the NPI associated with their CABHA MPN.

The **Request Form** and instructions can be found on DMA's Provider Forms web page at http://www.ncdhhs.gov/dma/provider/forms.htm. Providers who are new to billing or providers without an RA cover page must state on the form that an RA has not been received. Completed forms can be returned by fax to the HP Enterprise Services Electronic Commerce Unit at 919-859-9703 or by e-mail to ECSPDF@hp.com.

Authorization and Billing for Services after CABHA Certification but Prior to Enrollment

Once a provider becomes CABHA-certified and has submitted their Medicaid enrollment application but has not yet received their CABHA Medicaid number, **at their own risk**, they may choose to begin providing services. On the enrollment application they would list a date for enrollment to begin (this date can be the date of certification or a later date of the provider's choosing). If the provider does not choose a date of enrollment, CSC will choose the date the enrollment application is received. Upon receiving the CABHA MPN, they could submit requests for authorization to the UR vendor for dates with a start date for the authorization that must not be before the enrollment date. Any requests for authorization for services that took place prior to receiving the CABHA MPN should include the enrollment letter from CSC. In this process, providers run the risk that the UR vendor may not approve services as medically necessary or that an issue could arise in the enrollment process. Certification does not necessarily guarantee enrollment. Once a provider receives the authorization (but not before) they may submit claims for services rendered during that time period after certification but prior to enrollment.

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Clarification to Critical Access Behavioral Health Agency Certification and Endorsement for Community Support Team, Intensive In-Home, and Child and Adolescent Day Treatment Services after
January 1, 2011

This article is reprinted from the January 2011 Medicaid Bulletin with clarifications on the process for certification and endorsement (and endorsement renewal) of Community Support Team (CST), Intensive In-Home (IIH), or Child and Adolescent Day Treatment (DT) services.

Providers who want to become a CABHA after January 1, 2011, will follow the steps detailed in 10A NCAC 22P.0101 through .0603 [found on the Office of Administrative Hearings (OAH) website at http://www.oah.state.nc.us/rules]. These steps include submitting a letter of attestation (see Implementation Update #75 for information on this process), which must include evidence of the three core services (Comprehensive Clinical Assessment, Medication Management, and Outpatient Behavioral Health Therapy), two endorsed enhanced services to create an age and disability specific continuum, key leadership positions (medical director, clinical director, quality management/training director), 3-year national accreditation, etc. If, during a desk review, the attestation packet is found to be complete, the next step is the clinical interview followed by an on-site verification.

Providers may continue to apply for CABHA certification using the CABHA-only services of CST, IIH, or DT as one of the two endorsed services that create their age and disability specific continuum or as both of the two endorsed services that create their age and disability specific continuum (if using a child mental health continuum of IIH and DT).

For CST, IIH, or DT if the provider is not already endorsed for the service, the CABHA attestation letter and packet should be submitted to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) prior to applying for endorsement. DMH/DD/SAS will conduct a desk review and, if the provider meets the requirements of the CABHA desk review (except for endorsement), the provider will be contacted and may then apply to the local management entity (LME) for endorsement (CST, IIH, DT).

If the provider is already endorsed for CST, IIH, or DT and that endorsement is set to expire, the CABHA attestation letter and packet should be submitted to DMH/DD/SAS prior to applying for endorsement renewal. DMH/DD/SAS will conduct a desk review and, if the provider meets the requirements of the CABHA desk review (except for endorsement), the provider will be contacted and may then apply to the LME for endorsement (CST, IIH, DT) renewal. If the renewal timeframe runs out while the CABHA desk review is being conducted, the provider will not be required to go through the full endorsement application and review process but will still be able to go through the endorsement renewal process.

If the provider applies for endorsement for one or all of the services (CST, IIH, DT) before submitting the CABHA attestation letter and packet to DMH/DD/SAS, the LME will return the application and instruct the provider to reapply for endorsement once the desk review has been completed.

The CABHA desk review includes all of the required elements except the missing endorsement(s) for CST, IIH or DT. The LME will process the endorsement application for CST, IIH or DT once the provider has met all the other required elements of the CABHA full desk review. Upon endorsement, the provider must notify DMH/DD/SAS by e-mailing/faxing/or mailing a copy of the Notification of Endorsement Action (NEA) to be included in the attestation letter packet and to finalize the desk review process.

Providers that are currently endorsed for CST, IIH, and/or DT will be able to remain endorsed (as long as the NEA doesn't expire). However, they will not be eligible to receive authorizations or bill for services until they are CABHA-certified and enrolled. If an LME has recently involuntarily withdrawn a provider's endorsement for CST, IIH, and/or DT because the provider was not going to achieve certification as a CABHA, and the expiration date on the NEA has not occurred yet, the LME should reinstate the endorsement. Per the endorsement policy, effective January 1, 2011, providers will need to be serving

consumers within 60 calendar days of the date of the DMA enrollment letter and if not serving consumers within 60 calendar days of the date of the DMA enrollment letter, endorsement will be withdrawn.

Endorsement Triple Time Frames

This is to clarify that with the implementation of the new Endorsement Policy on January 1, 2011, the triple time frames outlined in Implementation Update #62 no longer apply.

Critical Access Behavioral Health Agencies Changes of Ownership, Mergers, and Acquisitions

Critical Access Behavioral Health Agencies must notify N.C. Medicaid when acquiring a Community Intervention Agency's services. The CABHA must also notify the LME(s) in the counties impacted by the change in ownership. The acquisition of a non-CABHA Community Intervention Service Agency is a two-step process. The first step is for the CABHA to complete a new enrollment application and indicate that it is being submitted due to a change of ownership. The second step is to complete a CABHA Addendum to Add Services to affiliate the Community Intervention Services with the CABHA.

Step One – Enrollment Application

Refer to the following instructions to ensure that the application is completed correctly.

- **Organization Information:** Enter the organization name, National Provider Identifier, Employer Identification Number, Month of Fiscal Year End and Doing Business As information, as applicable, associated with the CABHA Medicaid Provider Number.
- **Effective Date and Provider Number:** Enter the effective date for the acquisition. Select "Yes" to indicate that the CABHA is enrolled as a provider with DMA. Enter the Medicaid Provider Number associated with the CABHA.
- **Change of Ownership/Merger/Acquisition:** Select "Yes" to indicate that the application is being submitted as a change in ownership/merger/acquisition. Enter the date of the ownership change. Enter the Community Intervention core service Medicaid Provider Number assigned to the previous owner.
- **Provider Type:** Select Community Intervention Services.
- **CIS Services:** Select each Community Intervention Service that the CABHA is acquiring and has been endorsed to provide.
- **Certification, Licensure, Accreditation, and Endorsement:** Complete, as applicable, for the Community Intervention Services that the CABHA is acquiring and has been endorsed to provide.

Complete the remainder of the application, as applicable, with information for the Medicaid Provider Number associated with the CABHA.

The CABHA will be notified once the change of ownership (enrollment) process is completed. The notification will include a new Community Intervention core service Medicaid Provider Number and a new Medicaid Provider Number for each of the Community Intervention Services that the CABHA is acquiring and has been endorsed to provide.

Step Two – CABHA Addendum to Add Services

Once the change of ownership (enrollment) process is complete, the CABHA must submit a CABHA Addendum to Add Services to affiliate the newly acquired Community Intervention Services with the CABHA. Refer to the following instructions to ensure that the addendum is completed correctly.

- **Current Medicaid Provider Information and Contact Person:** Enter the information associated with the CABHA Medicaid Provider Number.
- **CABHA Service:** Indicate the CABHA services to be affiliated with the organization.
- **Attending Provider Information:** Using the information from the notification you received upon completion of the change of ownership (enrollment) process, enter the attending provider name, the Medicaid Provider Number, National Provider Identifier, and indicate the CABHA service. Repeat this step as needed to accommodate each service to be affiliated with the CABHA.

Complete the remainder of the addendum, as applicable, with information for the Medicaid Provider Number associated with the CABHA.

Billing Core Services "Incident To" the Medical Director or Other Critical Access Behavioral Health Agency Physician

Physician assistants, direct-enrolled licensed behavioral health professionals (per DMA Clinical Coverage Policy 8C) and provisionally licensed professionals providing any of the CABHA core services (comprehensive clinical assessments, outpatient therapy, medication management) within their scope of practice may render the service "incident to" a physician. This physician may be the CABHA medical director or another CABHA physician as long as the guidelines for billing "incident to," outlined in the March 2009 Medicaid Bulletin and the May 2005 Special Medicaid Bulletin are followed. As a reminder, the behavioral health professionals listed in DMA Clinical Coverage Policy 8C must be direct-enrolled with Medicaid. All Medicaid direct-enrolled providers may bill with their own "attending number."

When making a request for prior authorization for services that will be provided "incident to," the MPN of the physician should be listed as the "Attending Provider" on the ORF2. This individual physician MPN is the individual physician that the physician assistant, licensed behavioral health professional or provisionally licensed professional practices "incident to."

If individuals will be providing services "incident to" the CABHA medical director or another CABHA physician, the medical director's or physician's name and MPN need to have been included on the enrollment application (in the Attending Provider Information section). If this was not done at the time of the original CABHA enrollment, providers may complete item #4 on the Provider Change Form and an Electronic Claim Submission (ECS) Agreement from the NC Tracks website at http://www.nctracks.nc.gov/provider/cis.html.

Psychiatric CPT codes listed in DMA Clinical Coverage Policy 8C or in the March 2009 Medicaid Bulletin do not count towards the 22 annual visit limit for adults. Any E/M codes that are billed "incident to" (i.e., 99213 through 99215) a physician by a physician assistant or advanced practice nurse do count towards the 22 annual visit limit for adults. As a reminder, CABHAs must have a referral from a Community Care of N.C./Carolina ACCESS physician to provide and bill any E/M codes.

When submitting a claim for a core service that was rendered "incident to," the CABHA NPI is the billing number and the individual physician's NPI (associated with the MPN that was used to obtain the prior authorization) is the attending number. **It is imperative that documentation in the chart clearly indicate who provided the service and that it was provided "incident to," particularly in situations where the medical director is doing only administrative functions for the CABHA and is not directly billing for services. This information will be reviewed in monitoring visits and should clearly indicate who performed the service.**

Revision to Child/Adolescent Discharge/Transition Plan for Level III and IV Child Residential Services

Effective February 2011, the LME System of Care Coordinator (SOC) is required to sign all plans signifying receipt and review regardless of whether the SOC agrees with the plan; however, checkboxes have been added to allow the SOC to note whether they agree or disagree with the plan that has been developed. The SOC does not authorize services and the utilization review vendor still reviews for medical necessity. As a reminder, SECTION 10.68.A.(a)(7)(b) (d)(e)(f) notes for all new admissions to Level III and IV child residential services, length of stay is limited to no more than 120 days. [Note: For recipients under the age of 21, services may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.] All new admission and concurrent requests for Level III and IV child residential services must include a Child/Adolescent Discharge/Transition Plan in order for the request to be considered complete. Failure to submit a complete discharge plan will result in the request being returned as "Unable to Process."

Frequently Asked Questions Regarding the Implementation of Multisystemic Therapy

A couple of questions have arisen in regards to the implementation of Multisystemic Therapy (MST) as funded by Medicaid in North Carolina. The information below offers clarification.

Question #1

Is a full-time (1.0 FTE) MST supervisor required for each MST team?

Answer #1
Yes, the current definition is based on one FTE for the supervisor in MST. This is different from what is published by MST Inc. but reflects the current MST policy found in Clinical Coverage Policy 8A.

Question #2
The service definition requires a minimum of three (3) therapists for each MST team. Is it acceptable to have four (4) full-time (1.0 FTE) therapists on each team?

Answer #2
The definition requires four staff per team (including the supervisor) and it would be allowable to have an additional QP but the team member to family ratio of 1:5 remains the same and the limit of 20 families per team would not change.

Six-Hour Person-Centered Thinking MH/SA Recovery Training Curriculum Elements
The required elements for the development of a 6-hour MH/SA Person-Centered Thinking (PCT)/Recovery training may be found at: http://www.ncdhhs.gov/mhddsas/cabha/recovpct.htm. This 6-hour training can be provided to meet the 12-hour total requirement for PCT for Child and Adolescent Day Treatment, Intensive In-Home, Community Support Team and MH/SA Targeted Case Management staff who have already completed the 6-hour PCT training under the old requirement, per Implementation Update #82. All elements in the set chosen must be included in the training curriculum. Resources that may be used in developing training are also presented.

Medicaid Policy Updates
DMA Clinical Coverage Policy 8C has been updated to reflect the new 16 unmanaged visits for children. The effective date of the policy is January 1, 2011.

DMA Clinical Coverage Policy 8A will be updated later this month to include the new policy for Peer Support Services and policy updates to Community Support Team, Intensive In-Home, Child and Adolescent Day Treatment, and Outpatient Opioid Treatment. Please see ***Section 8.0 Policy Implementation/Revision Information*** for a complete list of changes. The effective date of the policy is January 1, 2011. Both policies can be accessed at http://www.ncdhhs.gov/dma/mp/index.htm.

Requesting Additional Information for Prior Approval (Update)
Periodically a provider may submit a request without sufficient clinical information for DMA or the vendor to make a decision on the request. Medicaid's policy is that DMA or the vendor must request the specific information needed in writing. The provider must respond to this request by submitting the needed information within 10 business days of the date of the written notice. There is no extension beyond the 10 business days. If the provider does not submit the information within 10 business days, the request is denied, and a written notice with appeal rights is generated. Even if the recipient files an appeal, a new request with the needed information may be submitted at any time.

CAP/MR-DD Utilization Review by Local Management Entities
Special Implementation Update #84 and the January Medicaid Bulletin announced that utilization review for CAP/MR-DD services will be provided by LMEs beginning January 20, 2011. Please note that fax numbers for the LMEs providing these services have been updated and are as follows:

Crossroads Behavioral Health Center
Contact Number: 336-835-1000
Fax Number: 336-827-8027

Eastpointe LME
Contact number: 1-800-513-4002
Fax Number: 910-298-7194

The Durham Center
Contact number: 919-560-7100
Fax Number: 919-560-7377

Pathways LME
Contact number: 1-855-728-4227
Fax Number: 1-855-728-4329

Supports Intensity Scale ™ Update

In early November the DMH/DD/SAS and the Developmental Disabilities Training Institute welcomed Robin Snead, MSW, LCSW to the Supports Intensity Scale™ Coordinator position. In this position Robin provides leadership and coordination of the implementation of the Supports Intensity Scale™ (SIS) throughout North Carolina through collaboration with the DMH/DD/SAS and LMEs.

As North Carolina moves from the Pilot Phase to statewide implementation of the SIS, Robin is involved in providing technical assistance, training and support to the LMEs, case managers, and SIS examiners. Robin is available to provide training events at the local level in order to increase the knowledge and awareness of the SIS, the use of the SIS in North Carolina, and the benefit of information gathered through the SIS assessment for use in the Person Centered Planning process.

To learn more about the SIS or to schedule training please contact Robin at: 919-715-2774 or rsnead@email.unc.edu.

Information about the Supports Intensity Scale™ is located on the DMH/DD/SAS website: http://www.ncdhhs.gov/mhddsas/sis/index.htm

CAP-MR/DD Update: Self-Direction with the Supports Waiver

We are pleased to announce the implementation of the Self Direction option within the CAP-MR/DD Supports Waiver. This is a new option available to individuals who are participants in the Supports Waiver and who choose to self-direct their waiver services and supports. This option is designed to provide choice to participants in managing their own waiver services and supports to live their best life. Based on an approved person centered plan and budget which include community-based services, supports, goods, and traditional services, participants in Self Direction will choose to direct some or all of their services.

In November and December 2010 DMH/DD/SAS conducted three trainings for LMEs and targeted case managers regarding the required components and implementation of the Self-Direction option. Updates to the DMH/DD/SAS Self-Direction web page include additional information and tools for use in implementation of the Self-Direction option by everyone involved. Additional information is being disseminated through the LMEs to individuals and families who participate in the Supports Waiver as well as trainings as part of CFAC and community advocacy groups across the state.

Individuals who are interested in participating in Self-Direction should notify their LME, as the LME is the access point for participants/family members who are interested in learning more about Self-Direction. The LME will provide information about what Self-Direction means and how participants become enrolled. Participants/family members, who receive funding through the CAP-MR/DD Supports Waiver, should contact their LME for information about this new opportunity. You can also contact Susie Equez at eguez@email.unc.edu or 919-715-2774, for further information.

Information about Self-Direction in the CAP-MR/DD Supports Waiver can be found on the DMH/DD/SAS website at: http://www.ncdhhs.gov/mhddsas/selfdirect/index.htm.

Effective April 30, 2011, LMEs Will No Longer Bill for T1999 Supplies for CAP MR/DD Waiver Recipients

Effective July 1, 2010, durable medical equipment (DME) providers became eligible to enroll with DMA as Community Alternatives Program (CAP) providers and bill for CAP-MR/DD waiver supplies (T1999). The UR Vendors will provide a service authorization to the CAP DME provider, which authorizes the amount

and codes that are approved on the CAP Cost Summary. The case manager is responsible for securing the signed and dated physician order and retaining it on file. The order must detail the specific quantity and frequency of the supplies. The DME vendor must send a copy of the itemized monthly invoice to the CAP-MR/DD case manager. Case managers are responsible for ensuring that DME providers comply with the authorized quantity. Case managers, DMA and applicable UR vendors will conduct random audits of DME CAP-MR/DD waiver charges. Any reimbursement for unauthorized supplies will be subject to recoupment by Program Integrity.

Use of the BO modifiers with procedure codes for enteral supplies being provided and billed as CAP-MR/DD waiver supplies apply only to recipients 21 years of age and older. These supplements do not need to be entered on the cost summary nor do they require prior approval by applicable UR vendor. For Medicaid recipients 20 years of age and younger, these products are currently available as a State Plan Service from an enrolled DME provider and are not covered as a waiver supply for children. For Non-Waiver recipients, please refer to the section on oral nutrition in Clinical Coverage Policy 5A, Durable Medical Equipment, for specific coverage information. The case manager is responsible for securing the signed and dated physician order and retaining it on file. The order must detail the specific quantity and frequency of the supplies. The DME vendor must send a copy of the itemized monthly invoice to the CAP case manager. Please note that enteral supplies do not count against the $3,000 limit for T1999.

Diapers and other incontinence supplies are regular DME supplies, not CAP MR/DD supplies. These should be billed by an enrolled DME provider. LMEs should not be billing for any regular DME supplies.

Post-Payment Reviews by Public Consulting Group

Since January 28, 2010, Public Consulting Group (PCG) has been assisting DMA's Program Integrity, Behavioral Health Review Section, in eliminating a backlog of cases and maintaining a steady rate of case reviews, preventing a future backlog of cases. PCG will continue to provide full scale operations, beginning with the receipt of a case file, conducting the administrative/clinical review, establishing a statistically valid claim review sample for review, and extrapolating these findings to calculate the overpayment. PCG is using the RAT-STATS Software 2007 Version 2.0 (Windows-based software approved by the U.S. Office of the Inspector General) to determine the sample size and extrapolated overpayment amount.

PCG will continue to initiate contact with the provider by sending the provider a certified cover letter from DMA and a PCG introduction letter with the request for records. PCG will inform the provider of the post-payment review process requirements and work closely with the provider and DMA. Providers are asked to submit documentation electronically via PCG secure web-based application. PCG will provide detailed instructions on how to submit records for the review, and will address provider questions regarding the post-payment review process. PCG has implemented a new call center at 888-805-1083, to handle the increased volume of provider calls and has developed a WebEx training to assist providers with navigating the PCG secure web-based application to upload provider documentation. Providers can access the WebEx training at https://web.pcgus.com/ncdma.

PCG will notify the provider regarding missing documentation and give the provider a designated timeframe to submit requested documentation. Once PCG has conducted its review of the documentation, if it finds the provider to be out of compliance, a Tentative Notice of Overpayment letter is sent to the provider. The provider will have reconsideration and appeals rights should he or she not agree with the findings of the review. Appeal instructions will be sent out with the Tentative Notice of Overpayment letter.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

cc: Secretary Lanier M. Cansler
Michael Watson
Beth Melcher
DMH/DD/SAS Executive Leadership Team
DMA Deputy and Assistant Directors
Jim Slate
Lisa Hollowell
Shawn Parker
Melanie Bush
Pam Kilpatrick
John Dervin
Lee Dixon
Sharnese Ransome